~~[after January first, nineteen hundred ninety five, the reimbursable base year administrative and general costs of a provider of services, excluding a provider of services reimbursed on an initial budget basis, and a new provider, excluding changes in ownership or changes in name, who begins operations in the year prior to the year which is used as a base year in determining rates of payment, shall not exceed thirty percent of total reimbursable base year operational costs of such provider of services.]~~

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TN 95-25 Approval Date FEB 11 1999

Supersedes TN 93-25 Effective Date APR 1 1995

TYPE OF SERVICE	METHOD OF REIMBURSEMENT
Assisted Living Programs	In accordance with Public Health law Section 3614(6) and 10 NYCRR Subpart 86-7, the Commissioner of Health and subject to approval for the State Director of the Budget, establishes per diem payment rates that are payment-in-full for the Title XIX Personal Care Services that the Assisted Living Program provides directly or through contracts with a Long Term Home Health Care Program, a certified home health agency or other qualified providers; nursing services, home health aid services, physical therapy, occupational therapy, speech equipment not requiring prior approval, personal emergency response services, and adult day health care provided in a program approved by the Commissioner of Health. Payment rates are established for 1992 for each of sixteen patient classification groups in each of sixteen regions, and the 1992 payment rates are increased by a roll factor for each subsequent year. The payment rates are related to fifty percent of the amounts which otherwise would have been expanded to provide the appropriate level of caré in a residential health care facility in the applicable regions and consist of a direct component and other than direct component. For 1992, the direct and other than direct components for each patient classification group in each of sixteen regions are summed and multiplied by fifty percent. For subsequent calendar years, the 1992 payment rates are increased by the applicable roll factor. Payment rates cannot exceed prevailing charges in the locality.

Type of Service	Method of Reimbursement
Prescribed Drugs	Reimbursement is the lowest of 1) the billing pharmacy's usual and customary price charged to the general public, 2) the upper limit if established by the Federal Government for specific multiple source drugs, plus a dispensing fee, or 3) the Estimated Acquisition Cost (EAC) established by State Department of Health, plus a dispensing fee. EAC is average wholesale price less ten percent. The dispensing fee for generic prescription drugs will be $4.50 per prescription and for brand name prescription drugs will be $3.50. The State Department of Health's prescription drug pricing service will determine whether a prescription drug is generic or brand name. Compound Drugs: - Reimbursement is determined by the State Department of Health at the cost of ingredients plus a dispensing fee of $3.50 with an additional amount of $0.75 as the compounding fee. Exception: Physician Override: Reimbursement for those brand name drugs for which there are generic equivalent drugs for which reimbursement is not to exceed the aggregate of the specified upper limit for the particular drug established by the Health Care Financing Administration, plus a dispensing fee, will be paid at the lower of the estimated acquisition cost, plus a dispensing fee, or at the provider's usual and customary price charged to the general public when the prescriber indicated that the brand name drug is required by placing "daw" (dispense as written) in the box located on the prescription form and by writing "brand necessary" or "brand medically necessary" in his/her own handwriting on the face of the prescription.

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TYPE OF SERVICE	METHOD OF REIMBURSEMENT
Nonprescription Drugs	Reimbursement is the lowest of 1) the usual and customary price charged to the general public, 2)the price established by the Commissioner of Health as shown on the NYS List of Medicaid Reimbursable Drugs for that generic category and strength in the package size nearest to that ordered; or 3) Acquisition cost plus dispensing fee.
Private Duty Nursing	Fees determined by local districts and reviewed by the Department of Social Services.
Physical Therapy	Fee Schedule developed by Department of Health and approved by Division of the Budget.
Occupational Therapy	Fee Schedule developed by Department of Health and approved by Division of the Budget.
Speech Pathology	Fee Schedule developed by Department of Health and approved by Division of the Budget.
Audiology	Fee Schedule developed by Department of Health and approved by Division of the Budget.
Eyeglasses and Other Visual Services	Fee Schedule developed by Department of Health and approved by Division of the Budget.
Hearing Aid Supplies and Services	Fee Schedule developed by Department of Health and approved by Division of the Budget.
Prosthetic and Orthotic Appliances	Payments are limited to the lower of the usual and customary charge to the general public or fee schedule developed by Department of Health and approved by Division of the Budget.

87-4 Supercedes 85-26

Approval Date JAN 18 1990

Effective Date JAN 1 1987

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TYPE OF SERVICE	METHOD OF REIMBURSEMENT
Comprehensive Psychiatric Emergency Programs	Flat fee developed by OMH and approved by the Division of the Budget.

TN 90-18 Approval Date MAR 2 3 1992

Supersedes TN None Effective Date JUN 1 1990

TYPE OF SERVICE	METHOD OF REIMBURSEMENT
Durable Medical Equipment	Purchase: Reimbursement must not exceed the lower of a) the maximum reimbursable amount as shown in the fee schedule for durable medical equipment; the maximum reimbursable amount will be determined for each item of durable medical equipment based on an average cost of products representative of that item; or b) the usual and customary price charged to the general public for same or similar products. When there is no price listed in the fee schedule for durable medical equipment, payment for purchase of durable medical equipment must not exceed the lower of a) acquisition cost as established by invoice detailing the line item cost to the provider from a manufacturer or wholesaler net any rebates, discounts or valuable consideration, mailing, shipping, handling, insurance, or sales tax plus fifty percent; or b) the usual and customary price charged to the general public for the same or similar products. When the primary payor is Medicare, payment for the purchase of durable medical equipment shall be the amount approved by Title XVIII of the Medicare Program. Rental: monthly rental charges are determined by the Department of Health.
Medical/Surgical Supplies	Purchase: reimbursement is determined by the Department of Health at the lower of the maximum reimbursable amount; or at the usual and customary price charged to the general public.
Enteral Formula	Purchase: reimbursement is the lower of the cost to the provider plus 50% or the usual and customary price charged to the general public.
Transportation	Fees determined by local social services districts and approved by the Division of the Budget and shall not exceed the current local prevailing charge or locally negotiated fee, whichever is lower, with the following exception: For those clients for whom the State retains fiscal and administrative responsibility, fees are determined by the DOH Office of Financial Management using the local social services district fee for a comparable service as the upper limit of payment.

TYPE OF SERVICE	METHOD OF REIMBURSEMENT
Out-of-State Services	Fee-based providers: Those providers who meet their state's licensure/certification requirements are reimbursed charges up to the appropriate New York State fee, for services rendered.
HMO's and Prepaid Health Plans	Monthly capitation rates established through negotiation with the Department of Health and approved by the Division of the Budget are in compliance with 42 CFR Part 434, Part 447.302 and Part 447.361 including all federal requirements for the reimbursement methodology.
PERSONAL CARE SERVICES	For personal care services provided pursuant to a contract between a social services district and a voluntary, proprietary or public personal care services provider, payment is made at the lower of the provider's charge to the general public for personal care services or a rate the Department establishes for the provider, subject to the approval of the Director of the Budget, in accordance with a cost-based methodology. Under the cost-based methodology, the Department determines a provider's rate based upon the provider's reported allowable costs, as adjusted by annual trend factors. The provider's rate includes payment for the provider's reported allowable trended costs only in an amount that does not exceed the ceilings for allowable costs that the Department has established for all providers in the applicable geographic group to which the provider belongs. The rate includes an adjustment for profit, for proprietary providers, or surplus, for voluntary providers. The final rate is payment-in-full for all personal care services provided during the applicable rate year, subject to any revisions made in accordance with rate revision or audit procedures. For personal care services provided by or under arrangements with individual providers, payment is made directly to the individual provider at a rate approved by the Department and the Director of the Budget.

TYPE OF SERVICE	METHOD OF REIMBURSEMENT
PERSONAL CARE SERVICES (cont.)	For personal care services provided directly by social services district staff, payment is made according to a salary schedule established by the social services district. For personal care services provided in family care homes certified or operated by the Office of Mental Health (OMH) or the Office of Mental Retardation and Developmental Disabilities (OMRDD), payment is made in accordance with a fee schedule developed by OMH or OMRDD, as appropriate, and approved by the Department and the Director of the Budget. For personal care services provided in community residences certified or operated by the Office of Mental Retardation and Developmental Disabilities (OMRDD), payment is made at hourly rates developed by OMRDD and approved by the Department and the Director of the Budget.

Section 86-2.9, Adult Day Health Care in Residential Health Care Facilities, is hereby amended to read as follows:

86-2.9 Adult Day Health Care in Residential Health Care Facilities: (a) Except as specifically identified in subdivision (g), rates for residential health care facility services for adult day health care registrants shall be computed on the basis of the allowable costs, as reported by the residential health care facility, and the total number of visits by adult day health care registrants, as defined in Part 425 of this Title, for which services were delivered pursuant to Article 6 of Subchapter A of Chapter V of this Title subject to the maximum daily rate provided for in this section.

(b) For adult day health care programs without adequate cost experience, rates will be computed based upon annual budgeted allowable costs, as submitted by the residential health care facility and the total estimated annual number of visits by adult day health care registrants, as defined in Part 425 of this Title, for which services were delivered pursuant to Article 6 of Subchapter A of Chapter V of this Title subject to the maximum daily rate provided for in this section.

(c) Allowable costs shall include, but are not limited to the following:

(1) applicable salary and nonsalary operating costs;

(2) costs of transportation; and

(3) appropriate portion of capital costs, allocated according to instructions accompanying the RHCF-4 report.

(d) the maximum daily rate, excluding the allowable costs of transportation, for services provided to a registrant in a 24-hour period as described in Part 425 of this title shall be 75 percent of the sponsoring facility's former skilled nursing facility rate in effect on January 1, 1990, with the operating component trended forward to the rate year by the sponsoring facility's trend factor.

(e) Notwithstanding subdivision (d) of this section or any other regulations to the contrary, for the period July 1, 1992 to March 31, 1993 and annual periods beginning April 1, thereafter, the maximum daily rate, excluding the allowable costs of transportation, for services provided to a registrant in a 24-hour period as described in Part 425 of this Title shall be 65 percent of the sponsoring facility's former skilled nursing facility rate in effect on January 1, 1990 with the operating component trended forward to the rate year by the sponsoring facility's trend factor.

TN 94-25 Approval Date JUN 2 6 1994
Supersedes TN 93-23 Effective Date APR 1 - 1993

APR 1 - 1994

(f) For facilities without a skilled nursing facility rate, computed in accordance with section 86-2.10 or section 86-2.15 of this Subpart, in effect on January 1, 1990, a weighted average rate for each region listed in Appendix 13A of this Title shall be used as the proxy for the facility's January 1, 1990 skilled nursing facility rate in determining the maximum daily rate for such facilities as set forth in subdivisions (d) and (e) of this section. The weighted average rate for each region shall be equal to the statewide weighted average 1990 skilled nursing facility rate with the statewide average direct component and indirect component of the rate adjusted respectively by the regional direct and indirect input price adjustment factors described in section 86-2.10. The statewide weighted average rate shall be computed by multiplying each residential health care facility's 1990 skilled nursing facility rate times its 1990 skilled nursing facility patient days, summing the result statewide, and dividing by the statewide total 1990 skilled nursing facility patient days. The 1990 rate used in computing the statewide weighted average rate shall be the latest 1990 rate in effect on July 1, 1992 for the former skilled nursing level of care which is contained in the rate which has been certified by the commissioner pursuant to section 2807(3) of the Public Health Law.

(g) Effective April 1, 1994 and thereafter reimbursement for Adult Day Health Care services provided to registrants with acquired immunedeficiency syndrome (AIDS) and other human immunodeficiency virus (HIV) related illnesses shall be established as follows. Payment shall be a per visit price with not more than one visit per day per registrant. The rate of payment shall consist of a single price per visit for the operating component, transportation, and the capital cost component and shall be based upon a rate of $160 per visit per 24 hour period. To be eligible for reimbursement a residential health care facility must be certified by the Department to provide adult day health care services for AIDS/HIV registrants. The price shall be full reimbursement for the following: (i) physician services, nursing services, and other related professional expenses directly incured by the licensed residential health care facility; (ii) administrative , personnel, business office, data processing, recordkeeping, housekeeping, food services, transportation, plant operation and maintenance and other related facility overhead expenses; (iii) all other services required for adult day health care in residential health care facilities appropriate to the level of general medical care required by the patient; (iv) all medical supplies, immunizations, and drugs directly related to the provision of services except for those drugs used to treat AIDS